CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Provider Operations

(Amendment)

907 KAR 1:038. Hearing Program coverage provisions and requirements[~~Hearing and Vision Program services~~].

RELATES TO: KRS 205.520, 334.010(4), (9), 334A.020(5), 334A.030, 42 C.F.R. 441.30, 447.53, 457.310, 42 U.S.C. 1396a, b, d, 1396r-6

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds[~~for the provision of medical assistance to Kentucky's indigent citizenry~~]. This administrative regulation establishes the Medicaid program provisions and requirements regarding the coverage of audiology services and hearing instruments[~~hearing services and vision services for which payment shall be made by the Medicaid Program~~].

Section 1. Definitions. (1) "Audiologist" is defined by KRS 334A.020(5).

(2) [~~"Comprehensive choices" means a benefit plan for an individual who:~~

~~(a) Meets the nursing facility patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. A nursing facility in accordance with 907 KAR 1:022;~~

~~2. The Acquired Brain Injury Waiver Program in accordance with 907 KAR 3:090;3. The Home and Community Based Waiver Program in accordance with 907 KAR 1:160; or~~

~~4. The Model Waiver II Program in accordance with 907 KAR 1:595; and~~

~~(c) Has a designated package code of F, G, H, I, J, K, L, M, O, P, Q, or R.~~

~~(3)~~] "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(3)[~~(4)~~] "Department" means the Department for Medicaid Services or its designee.

(4) “Enrollee” means a recipient who is enrolled with a managed care organization.

(5) “Federal financial participation” is defined by 42 C.F.R. 400.203.

(6) “Healthcare Common Procedure Coding System” or “HCPCS” means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or time.

(7)[~~(5) "Emergency" means that a condition or situation requires an emergency service pursuant to 42 C.F.R. 447.53.~~

~~(6) "Family choices" means a benefit plan for an individual who:~~

~~(a) Is covered pursuant to:~~

~~1. 42 U.S.C. 1396a(a)(10)(A)(i)(I) and 1396u-1;~~

~~2. 42 U.S.C. 1396a(a)(52) and 1396r-6 (excluding children eligible under Part A or E of title IV, codified as 42 U.S.C. 601 to 619 and 670 to 679b);~~

~~3. 42 U.S.C. 1396a(a)(10)(A)(i)(IV) as described in 42 U.S.C. 1396a(l)(1)(B);~~

~~4. 42 U.S.C. 1396a(a)(10)(A)(i)(VI) as described in 42 U.S.C. 1396a(l)(1)(C);~~

~~5. 42 U.S.C. 1396a(a)(10)(A)(i)(VII) as described in 42 U.S.C. 1396a(l)(1)(D); or~~

~~6. 42 C.F.R. 457.310; and~~

~~(b) Has a designated package code of 2, 3, 4, or 5.~~

~~(7) "Global choices" means the department's default benefit plan, consisting of individuals designated with a package code of A, B, C, D, or E and who are included in one (1) of the following populations:~~

~~(a) Caretaker relatives who:~~

~~1. Receive K-TAP benefits and are deprived due to death, incapacity, or absence;~~

~~2. Do not receive K-TAP benefits and are deprived due to death, incapacity, or absence; or~~

~~3. Do not receive K-TAP benefits and are deprived due to unemployment;~~

~~(b) Individuals aged sixty-five (65) and over who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. Receive SSP benefits and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(c) Blind individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(d) Disabled individuals who receive SSI benefits and:~~

~~1. Do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022, including children; or~~

~~2. SSP benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(e) Individuals aged sixty-five (65) and over who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status criteria in accordance with 907 KAR 1:022;~~

~~(f) Blind individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

~~(g) Disabled individuals who have lost SSI or SSP benefits, are eligible for "pass through" Medicaid benefits, and do not meet nursing facility patient status in accordance with 907 KAR 1:022;~~

~~(h) Pregnant women; or~~

~~(i) Medicaid works individuals.~~

~~(8)~~] "Hearing instrument" is defined by KRS 334.010(4).

(8) “Managed care organization” means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(9) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(10) “Recipient” is defined by KRS 205.8451(9).[~~"Nonemergency" means that a con-~~

~~dition or situation does not require an emergency service pursuant to 42 C.F.R. 447.53~~]

(11) [~~"Optimum choices" means a benefit plan for an individual who:~~

~~(a) Meets the intermediate care facility for individuals with mental retardation or a developmental disability patient status criteria established in 907 KAR 1:022;~~

~~(b) Receives services through either:~~

~~1. An intermediate care facility for individuals with mental retardation or a developmental disability in accordance with 907 KAR 1:022; or~~

~~2. The Supports for Community Living Waiver Program in accordance with 907 KAR 1:145; and~~

~~(c) Has a designated package code of S, T, U, V, W, X, Z, 0, or 1.~~

~~(12)~~] "Specialist in hearing instruments" is defined by KRS 334.010(9).

Section 2. General Requirements. (1)(a) For the department to reimburse for a service or item, the service or item shall:

1. Be provided:

a. To a recipient under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21); and

b. By a provider who is:

(i) Enrolled in the Medicaid program pursuant to 907 KAR 1:672;

(ii) Currently participating in the Medicaid program pursuant to 907 KAR 1:671; and

(iii) Authorized to provide the service in accordance with this administrative regulation;

2. Be covered in accordance with this administrative regulation;

3. Be medically necessary;

4. Have a CPT code or HCPCS code that is listed on the Department for Medicaid Services Hearing Program Fee Schedule.

(b) In accordance with Section 3(3) of 907 KAR 17:010, a provider of a service to an enrollee shall not be required to be currently participating in the Medicaid program if the managed care organization in which the enrollee is enrolled does not require the provider to be currently participating in the Medicaid program.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3) A provider shall comply with:

(a) 907 KAR 1:671;

(b) 907 KAR 1:672; and

(c) All applicable state and federal laws.

(4)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this section may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(c) Non-duplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(d) A provider shall comply with KRS 205.622.

(5)(a) An in-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license in accordance with KRS Chapter 334A;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department; and

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department.

(b) An out-of-state audiologist shall:

1. Maintain a current, unrevoked, and unsuspended license to practice audiology in the state in which the audiologist is licensed;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association if the audiologist is out of state.

(c) If an audiologist fails to comply with paragraph (a) or (b), as applicable based on if the audiologist is in-state or out-of-state, the:

1. Audiologist shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the audiologist effective with the date the audiologist fails or failed to comply.

(6)(a) An out-of-state hearing instrument dispenser shall:

1. Maintain a current, unrevoked, and unsuspended license issued by the licensing board with jurisdiction over hearing instrument dispensers in the state in which the license is held;

2. Before initially enrolling in the Kentucky Medicaid Program, submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

3. Annually submit proof of the license referenced in subparagraph 1 of this paragraph to the department;

4. Maintain a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association; and

5. Before enrolling in the Kentucky Medicaid Program, submit proof of a Certificate of Clinical Competence issued to the audiologist by the American Speech-Language-Hearing Association.

(c) If a specialist in hearing instruments fails to comply with paragraph (a) or (b), as applicable based on if the specialist in hearing instruments is in-state or out-of-state, the:

1. Specialist in hearing instruments shall be ineligible to be a Kentucky Medicaid Program provider; and

2. Department shall not reimburse for any service or item provided by the specialist in hearing instruments effective with the date the specialist in hearing instruments fails or failed to comply.

Section 3. Audiology Services. (1) Audiology service [~~Hearing Services. (1) All hearing~~]coverage shall be limited to:

(a) A service provided:

1. To a recipient[~~Limited to an individual~~] under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21); and

2. By an audiologist who:

a. Is enrolled in the Medicaid program pursuant to 907 KAR 1:672;

b. Is currently participating in the Medicaid program pursuant to 907 KAR 1:671; and

c.(i) Meets the in-state audiologist requirements established in Section 2(5) of this administrative regulation if the audiologist is an in-state audiologist; or

(ii) Meets the out-of-state audiologist requirements established in Section 2(6) of this administrative regulation if the audiologist is an out-of-state audiologist;

(b) A medically necessary service;

(c) One (1) complete hearing evaluation per calendar year; and

(d) A CPT code or HCPCS code list on the Department for Medicaid Services Hearing Program Fee Schedule[~~; and~~

~~(b) Provided in accordance with the Hearing Program Manual~~].

(2) Unless a recipient's health care provider demonstrates, and the department agrees, that an additional hearing instrument evaluation is medically necessary, a ~~services in excess of the limitations established in this subsection are medically necessary,~~

~~reimbursement for services provided by an audiologist licensed pursuant to KRS 334A.030 to a recipient shall be limited to:~~

~~(a) The following procedures which shall be covered only if a recipient is referred by a physician to an audiologist licensed pursuant to KRS 334A.030:~~

~~Code~~	~~Procedure~~
~~92552~~	~~Pure Tone audiometry (threshold); air only~~
~~92555~~	~~Speech audiometry threshold~~
~~92556~~	~~Speech audiometry threshold; with speech recognition~~
~~92557~~	~~Comprehensive audiometry evaluation~~
~~92567~~	~~Tympanometry~~
~~92568~~	~~Acoustic reflex testing~~
~~92579~~	~~Visual reinforcement audiometry~~
~~92585~~	~~Auditory evoked potentials~~
~~92587~~	~~Evoked otoacoustic emissions~~
~~92588~~	~~Complete or diagnostic evaluation (comparison of transient or distortion product otoacoustic emissions at multiple levels and frequency)~~
~~92541~~	~~Spontaneous nystagmus test~~
~~92542~~	~~Positional nystagmus test~~
~~92543~~	~~Caloric vestibular test~~
~~92544~~	~~Optokinetic nystagmus test~~

~~92545~~	~~Oscillating tracking test~~
~~92546~~	~~Sinusodial vertical axis rotational testing~~
~~92547~~	~~Use of vertical electrodes~~

[~~(b) Complete hearing evaluation;~~

~~(c)~~] hearing instrument evaluation shall:

(a) Be limited to being provided to an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Include three (3) follow-up visits which shall be:

1. Within the six (6)-month period immediately following the fitting of a hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument; and

(c) Include one (1) additional follow-up visit which shall be[~~;~~

~~(d) Three (3) follow-up visits that shall be:~~

~~1. Within the six (6) month period immediately following fitting of a hearing instrument; and~~

~~2. Related to the proper fit and adjustment of the hearing instrument; and~~

~~(e) One (1) additional follow-up visit that is~~]:

1. At least six (6) months following the fitting of the hearing instrument; and

2. Related to the proper fit and adjustment of the hearing instrument.

(3)(a) A referral by a physician to an audiologist shall be required for an audiology service.

(b) The department shall not cover an audiologist service if no referral from a physi-

cian to the audiologist was made.

Section 4. Hearing Instrument Coverage. [~~(3)~~] Hearing instrument benefit coverage shall:

(1) Be limited to a benefit:

(a) For an individual under the age of twenty-one (21) years, including the month in which the individual becomes twenty-one (21);

(b) Provided by a specialist in hearing instruments or audiologist who meets the:

1. In-state specialist in hearing instruments requirements established in Section 2(6) of this administrative regulation if the specialist in hearing instruments is an in-state specialist in hearing instruments; or

2. Out-of-state audiologist requirements established in Section 2(6) of this administrative regulation if the audiologist is an out-of-state audiologist;

(c) That is medically necessary; and

(d) That has a corresponding HCPCS code listed on the Department for Medicaid Services Hearing Program Fee Schedule.

(2) If the benefit is a hearing instrument model, [~~(a)~~] be for a hearing instrument model that is:

(a)[~~1.~~] Recommended by an audiologist licensed pursuant to KRS 334A.030; and

(b)[~~2.~~] Available through a Medicaid-participating specialist in hearing instruments; and

(3)[~~(b)~~] Not exceed $800 per ear every thirty-six (36) months.[~~; and~~

~~(c) Be limited to the following procedures:~~

Code	Procedure
V5010	Assessment for Hearing instrument
V5011	Fitting, Orientation, Checking of Hearing instrument
V5014	Repair, Modification of Hearing Instrument
V5015	Hearing Instrument Repair Professional Fee
V5020	Conformity Evaluation
V5030	Hearing Instrument, Monaural, Body Aid Conduction
V5040	Hearing Instrument, Monaural, Body Worn, Bone Conduction
V5050	Hearing Instrument, Monaural, In the Ear Hearing
V5060	Hearing Instrument, Monaural, Behind the Ear Hearing
V5070	Glasses; Air Conduction
V5080	Glasses; Bone Conduction
V5090	Dispensing Fee, Unspecified Hearing Instrument
V5095	Semi-Implantable Middle Ear Hearing Prosthesis
V5100	Hearing Instrument, Bilateral, Body Worn
V5120	Binaural; Body
V5130	Binaural; In the Ear
V5140	Binaural; Behind the Ear
V5150	Binaural; Glasses
V5160	Dispensing Fee, Binaural
V5170	Hearing Instrument, Cros, In the Ear
V5180	Hearing Instrument, Cros, Behind the Ear

~~V5190~~	~~Hearing Instrument, Cros, Glasses~~
~~V5200~~	~~Dispensing Fee, Cros~~
~~V5210~~	~~Hearing Instrument, Bicros, In the Ear~~
~~V5220~~	~~Hearing Instrument, Bicros, Behind the Ear~~
~~V5230~~	~~Hearing Instrument, Bicros, Glasses~~
~~V5240~~	~~Dispensing Fee, Bicros~~
~~V5241~~	~~Dispensing Fee, Monaural Hearing Instrument, Any Type~~
~~V5242~~	~~Hearing Instrument, Analog, Monaural, CIC (Completely In the Ear Canal)~~
~~V5243~~	~~Hearing Instrument, Analog, Monaural, ITC (In the Canal)~~
~~V5244~~	~~Hearing Instrument, Digitally Programmable Analog, Monaural, CIC~~
~~V5245~~	~~Hearing Instrument, Digitally Programmable Analog, Monaural, ITC~~
~~V5246~~	~~Hearing Instrument, Digitally Programmable Analog, Monaural, ITE (In the Ear)~~
~~V5247~~	~~Hearing Instrument, Digitally Programmable Analog, Monaural, BTE (Behind the Ear)~~
~~V5248~~	~~Hearing Instrument, Analog, Binaural, CIC~~
~~V5249~~	~~Hearing Instrument, Analog, Binaural, ITC~~
~~V5250~~	~~Hearing Instrument, Digitally Programmable Analog, Binaural, CIC~~

~~V5251~~	~~Hearing Instrument, Digitally Programmable Analog, Binaural, ITC~~
~~V5252~~	~~Hearing Instrument, Digitally Programmable, Binaural, ITE~~
~~V5253~~	~~Hearing Instrument, Digitally Programmable, Binaural, BTE~~
~~V5254~~	~~Hearing Instrument, Digital, Monaural, CIC~~
~~V5255~~	~~Hearing Instrument, Digital, Monaural, ITC~~
~~V5256~~	~~Hearing Instrument, Digital, Monaural, ITE~~
~~V5257~~	~~Hearing Instrument, Digital, Monaural, BTE~~
~~V5258~~	~~Hearing Instrument, Digital, Binaural, CIC~~
~~V5259~~	~~Hearing Instrument, Digital, Binaural, ITC~~
~~V5260~~	~~Hearing Instrument, Digital, Binaural, ITE~~
~~V5261~~	~~Hearing Instrument, Digital, Binaural, BTE~~
~~V5262~~	~~Hearing Instrument, Disposable, Any Type, Monaural~~
~~V5263~~	~~Hearing Instrument, Disposable, Any Type, Binaural~~
~~V5264~~	~~Ear Mold (One (1) Ear Mold Per Year Per Ear and if Medically Necessary)]~~
~~V5266~~	~~Hearing Instrument Battery (Limit of Four (4) Per Instrument When Billed With A New Hearing Instrument Or A Replacement Instrument)~~
~~V5267~~	~~Hearing Instrument Supplies, Accessories~~
~~V5299~~	~~Hearing Service Miscellaneous (May Be Used to Bill Warranty Replacement Hearing Instruments But Shall be Covered Only if~~

	~~Prior Authorized by the Department)~~

Section 5. Replacement of a Hearing Instrument. (1) The department shall reimburse for the replacement of a hearing instrument if:

(a) A loss of the hearing instrument necessitates replacement;

(b) Extensive damage has occurred necessitating replacement; or

(c) A medical condition necessitates the replacement of the previously prescribed instrument or equipment in order to accommodate a change in hearing loss.

(2) If replacement of a hearing instrument is necessary within twelve (12) months of the original fitting, the replacement hearing instrument shall be fitted upon the signed and dated recommendation from an audiologist.

(3) If replacement of a hearing instrument becomes necessary beyond twelve (12) months from the original fitting:

(a) The recipient shall be examined by a physician with a referral to an audiologist; and

(b) The recipient's hearing loss shall be re-evaluated by an audiologist.

Section 6. Non-covered services. The department shall not reimburse for:

(1) A routine screening of an individual or group of individuals for identification of a hearing problem;

(2) Hearing therapy except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;

(3) Lip reading instructions except as covered through the six (6)-month adjustment counseling following the fitting of a hearing instrument;

(4) A service for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment;

(5) A telephone call;

(6) A service associated with investigational research; or

(7) A replacement of a hearing instrument for the purpose of incorporating a recent improvement or innovation unless the replacement results in appreciable improvement in the recipient's hearing ability as determined by an audiologist.

Section 7. Equipment. (1) Equipment used in the performance of a test shall meet the current standards and specifications established by the American National Standards Institute.

(2)(a) A provider shall ensure that any audiometer used by the provider or provider's staff shall:

1. Be checked at least once per year to ensure proper functioning; and

2. Function properly.

(b) A provider shall:

1. Maintain proof of calibration and any repair, if any repair occurs; and

2. Make the proof of calibration and repair, if any repair occurs, available for departmental review upon the department's request.

Section 8. Federal Approval and Federal Financial Participation. The department's coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services' approval for the coverage.

Section 9.[~~3. Vision Program Services. (1) Vision program coverage shall be limited~~

~~to:~~

~~(a) A prescription service;~~

~~(b) A repair service made to a frame;~~

~~(c) A diagnostic service provided by:~~

~~1. An ophthalmologist; or~~

~~2. An optometrist to the extent the optometrist is licensed to perform the service.~~

~~(2) Eyeglass coverage shall:~~

~~(a) Be limited to a recipient who is under age twenty-one (21); and~~

~~(b) Not exceed:~~

~~1. $200 per year for a recipient in the global choices benefit package; or~~

~~2. $400 per year for a recipient in the comprehensive choices, family choices, or optimum choices benefit package.~~

~~(3) To be covered:~~

~~(a) A service designated as a physical medicine and rehabilitation service CPT code shall require prior authorization if provided to a recipient age twenty-one (21) or over;~~

~~(b) A radiology service specified in 907 KAR 3:005, Section 5, shall require prior authorization regardless of a recipient's age;~~

~~(c) A service shall be provided in accordance with the Vision Program Manual; and~~

~~(d) A lens shall be polycarbonate and scratch coated.~~

~~Section 4.~~] Appeal Rights. [~~(1)~~] An appeal of a negative action regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

[~~(2) An appeal of a negative action regarding Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.~~

~~(3) An appeal of a negative action regarding a Medicaid provider shall be in accordance with 907 KAR 1:671.~~]

Section 10.[~~5.~~] Incorporation by Reference. (1) The "Department for Medicaid Services Hearing Program Fee Schedule", December 2013, [~~following material~~] is incorporated by reference[~~:~~

~~(a) "The Vision Program Manual", October 2007 edition, Department for Medicaid Services; and~~

~~(b) "The Hearing Program Manual", October 2007 edition, Department for Medicaid Services~~].

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, Cabinet for Health and Family Services, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at http://www.chfs.ky.gov/dms/incorporated.htm. (Recodified from 904 KAR 1:038, 6-10-86; Am. 18 Ky.R. 1625; eff. 1-10-92; 20 Ky.R. 1714; eff. 2-2-94; 23 Ky.R. 4009; 24 Ky.R. 119; eff. 6-18-97; 25 Ky.R. 1254; 1660; eff. 1-19-99; 28 Ky.R. 944; 1404; eff. 12-19-2001; 33 Ky.R. 594; 1377; 1560; eff. 1-5-07; 34 Ky.R. 1820; 2110; eff. 4-4-08.)

907 KAR 1:038

REVIEWED:

Date	Lawrence Kissner, Commissioner Department for Medicaid Services

APPROVED:

Date	Audrey Tayse Haynes, Secretary Cabinet for Health and Family Services

907 KAR 1:038

PUBLIC HEARING AND PUBLIC COMMENT PERIOD

A public hearing on this administrative regulation shall, if requested, be held on February 21, 2014 at 9:00 a.m. in Suite B of the Health Services Auditorium, Health Services Building, First Floor, 275 East Main Street, Frankfort, Kentucky, 40621. Individuals interested in attending this hearing shall notify this agency in writing February 14, 2014, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until February 28, 2014. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Tricia Orme, tricia.orme@ky.gov, Office of Legal Services, 275 East Main Street 5 W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:038
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen (502) 564-4321

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by establishing Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by establishing Kentucky Medicaid Hearing Program's service and coverage provisions and requirements.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: This amendment eliminates the definitions of and references to four (4) benefit plans – comprehensive choices, family choices, global choices, and optimum choices; removes vision program provisions as they are being addressed in a separate administrative regulation; clarifies the age limit for audiology services; incorporates by reference a fee schedule which establishes the services with corresponding Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes covered by DMS; un-incorporates the Hearing Program Manual and inserts provisions from the manual into this administrative regulation; inserts program integrity requirements; inserts a section to address hearing instrument coverage; inserts a section addressing hearing instrument replacement; and establishes that the coverage provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding. Included in the existing vision provisions (all of which are being removed and inserted into a new administrative regulation - 907 KAR 1:632) are the $200 and $400 annual limits on eyewear. Those limits (along with all other vision provisions) are being deleted from this administrative regulation; however, those limits will not be included in the new vision services administrative regulation as annual dollar limits on benefits violates an Affordable Care Act mandate. This amended administrative regulation is being promulgated in concert with

three (3) other related administrative regulations– 907 KAR 1:039, Hearing program reimbursement provisions and requirements; 907 KAR 1:631, Vision program reimbursement provisions and requirements; and 907 KAR 1:632, Vision program coverage provisions and requirements.]

(b) The necessity of the amendment to this administrative regulation: Eliminating the references to the four (4) benefit plans is necessary as DMS is eliminating the four (4) benefit plans [via a companion repealer administrative regulation which will repeal the administrative regulation (907 KAR 1:900, KyHealth Choices) which created the four (4) plans.] Eliminating provisions regarding vision service coverage is necessary as those provisions are being established in a new, separate administrative regulation; eliminating the manual previously incorporated by reference is necessary as provisions previously contained in the manual are being inserted into the body of this administrative regulation; and inserting program integrity requirements is necessary to enhance program integrity. Adopting a fee schedule is necessary to provide information in a reader friendly format for providers (via the fee schedule incorporated by reference.) Additionally, the $200 and $400 annual limits on eye glasses must be removed as a result of a federal mandate. The Affordable Care Act prohibits - effective January 1, 2014 - the application of an annual dollar limit on health insurance benefits known as “essential health benefits.” Medicaid benefits are within the scope of essential health benefits. Again, vision service provisions are being simultaneously established in a new and separate administrative regulation (907 KAR 1:632), but this amended administrative regulation had to be promulgated in concert with the new vision administrative regulation as this administrative regulation contained vision program provisions including the federally prohibited annual dollar limit. Establishing that the provisions in this administrative regulation are contingent upon the receipt of federal approval and federal funding is necessary to protect Kentucky taxpayer monies from being used if federal matching funding is not being provided.

(c) How the amendment conforms to the content of the authorizing statutes: This amendment conforms to the content of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating references to four (4) benefit plans which DMS is eliminating.

(d) How the amendment will assist in the effective administration of the statutes: This amendment will assist in the effective administration of the authorizing statutes by complying with a federal mandate; by preventing a potential loss of state funds; by eliminating provisions regarding vision service coverage as they are being addressed in a separate administrative regulation; by inserting provisions from a manual previously incorporated by reference into the body of this administrative regulation; by enhancing program integrity; by providing information in a reader friendly format for providers; and by eliminating

references to four (4) benefit plans which DMS is eliminating.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: For calendar year 2012, eleven (11) specialists in hearing instruments billed the Medicaid program [either a managed care organization or "fee-for-service Medicaid (non-managed care)] for services rendered and sixty-nine (69) audiologists billed the Medicaid program. 3,510 individuals (managed care and fee-for-service combined) received services from specialists in hearing instruments in calendar year 2012 and 3,236 individuals (managed care and fee-for-service combined) received services from audiologists during the same period.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. No actions are required by the amendment other than to properly bill for services and adhere to program integrity requirements.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed by the amendment.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients will benefit due to the elimination of an annual dollar limit on eyeglasses. Medicaid providers may benefit from having a reader friendly fee schedule to view and from clarifications.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: In calendar year 2012, the Department for Medicaid Services (DMS), i.e. "fee-for-service" or "FFS" paid almost $6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid $342,348 in claims to specialists in hearing instruments. For the same period DMS paid $13,191 in claims to audiologists and Medicaid managed care organizations paid $340,513 in claims to audiologists.

(b) On a continuing basis: DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching state funds appropriated in the biennium budget.

(7) Provide an assessment of whether an increase in fees or funding will be neces-

sary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement the amendment.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither imposes nor increases any fees.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used) Tiering is applied as hearing services are limited to individuals under twenty-one (21) years of age as this is a component of mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services pursuant to 42 U.S.C. 1396d(r)(4) and 42 C.F.R. 441.56.

FEDERAL MANDATE ANALYSIS COMPARISON

Administrative Regulation Number: 907 KAR 1:038
Agency Contact Person: Stuart Owen (502) 564-4321

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396d(r)(4), 42 U.S.C. 1396a(a)(30)(A), 42 C.F.R. 441.56, Section 2711 of the Affordable Care Act, and 45 C.F.R. 147.126.

2. State compliance standards. KRS 194A.050(1) states, “The secretary shall promulgate, administer, and enforce those administrative regulations necessary to implement programs mandated by federal law, or to qualify for the receipt of federal funds and necessary to cooperate with other state and federal agencies for the proper administration of the cabinet and its programs.”

   KRS 205.520(3) states: “ . . . it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect.”

3. Minimum or uniform standards contained in the federal mandate. EPDST hearing coverage must include at least testing and diagnosis and treatment for hearing defects, including hearing aids. Hearing services must also be, “provided—
   (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and
   (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition.”

   Additionally, state Medicaid programs are required to take measures to monitor that services are appropriate. States are required to establish a plan for review of the appropriateness and quality of care and services furnished to Medicaid recipients by appropriate health care professionals. The plan helps protect against overutilization or unnecessary care and to assure that reimbursement is consistent with efficiency, economy and quality of care.

   42 U.S.C. 1396a(a)(30)(A) requires Medicaid state plans to:
   “. . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services . . . .”

45 C.F.R. 147.126 prohibits the application of annual dollar limits on essential health benefits. Medicaid program benefits are included in the scope of essential health benefits.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? No.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The requirements are not stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Administrative Regulation Number: 907 KAR 1:038
Agency Contact Person: Stuart Owen (502) 564-4321

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services (DMS) will be affected by this amendment.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. 42 C.F.R. 441.56. and this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

   (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? The amendment will generate no revenue for DMS.
   (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? The amendment will generate no revenue for DMS.
   (c) How much will it cost to administer this program for the first year? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. “fee-for-service” or “FFS” paid almost $6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid $342,348 in claims to specialists in hearing instruments. For the same period DMS paid $13,191 in claims to audiologists and Medicaid managed care organizations paid $340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.
   (d) How much will it cost to administer this program for subsequent years? In calendar year 2012, the Department for Medicaid Services (DMS), i.e. “fee-for-service” or “FFS” paid almost $6,000 in claims to specialists in hearing instruments and Medicaid managed care organizations paid $342,348 in claims to specialists in hearing instruments. For the same period DMS paid $13,191 in claims to audiologists and Medicaid managed care organizations paid $340,513 in claims to audiologists. DMS anticipates no cost as a result of this amendment. DMS anticipates that paid claims (fee-for-service and managed care) in calendar years 2013 and 2014 will be similar to calendar year 2012 expenditures.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.
Revenues (+/-): ____

Expenditures (+/-): ____
Other Explanation:

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 1:038

(1) The “Department for Medicaid Services Hearing Program Fee Schedule”, December 2013, is incorporated by reference. This two (2)-page document lists audiology services, hearing instruments and related items - by CPT code or HCPCS code - that are covered by the Kentucky Medicaid Program.

(2) The “Hearing Program Manual”, October 2007, and the “Vision Program Manual,” October 2007, are being unincorporated from the material incorporated by reference. Hearing program provisions are established in the body of this administrative regulation and vision program provisions are no longer addressed in this administrative regulation.